Cherry Blossom Dental Care
Distinctive Dentistry

Fay Nazari DDS PC
1899 E. Roseville Pkwy
Suite 160
Roseville, CA 95661

AUTHORIZATION FOR RELEASE OF INDENTIFYING HEALTH INFORMATION

Patient(s) Name: ____
Patient Address: ____
Patient Phone Number: ____
Patient(s) Date of Birth: ____

I authorize CBDC/DD to disclose identifying protected health information. I understand that the person(s) listed in this form below have been authorized be myself to receive information about myself as specifically stated in the form below. I understand that by leaving the below section incomplete that CBDC/DD does not have my permission to discuss any of my identifying protected health information with any persons not authorized in this form or verbally consented to. I understand that CBDC/DD is legally obligated and will notify me of their required release of my identifying protected health information to release certain information without my permission as stated in their HIPPA Notice of Privacy Practices to certain federal agencies. CBDC/DD cannot withhold treatment of a patient unwilling to sign this form. I understand that at anytime I can revoke the right to release information by giving right documentation in doing so.

1. I authorize CBDC/DD to disclose identifying protected health information to the following person(s):

2. I authorize CBDC/DD to disclose identifying protected health information of the following information only:

3. I authorize CBDC/DD to disclose identifying protected health information during the time frame of:

I am allowing CBDC/DD to release detailed information to myself and the above listed person(s) by: phone message ___________(Initial), email ________ (Initial), text __________(Initial)

I have read and understand this form. I understand that CBDC/DD is legally obligated by Federal Laws as stated in the HIPPA Notice of Privacy Practices. By signing this form I have given CBDC/DD permission only to release information to the person(s) listed above.

Patient/Parent/Guardian Signature: ___________________________ Date: ____________

If the patient is a minor, Parent/Guardian Name: ____________________

Signature:__________ Relationship to Patient: ________________ Date: _______________